plete records for the revascularization and wound care. Analysis of degree and rate of healing was performed based on initial wound size.

Results: The study included 142 LEB and 148 EV patients with similar age (EV 70, LEB 71), diabetes mellitus (EV 58%, LEB 41%), and chronic renal failure (EV 24%, LEB 21%). EV procedures (balloon angioplasty n = 20, stent deployment n = 82, atherectomy n = 30, and cryoplasty n = 10) treated SFA (30%), popliteal (19%), and tibial (51%) lesions with 2.8 lesions treated per patient. LEB included 98 vein grafts and 44 using PTFE with a distal vein patch. Target arteries included BK popliteal (n = 14), anterior tibial (n = 46), posterior tibial (n = 41), and peroneal (n = 41). There was no difference in average initial wound size (EV 14.1mm, LEB 14.6mm) with complete healing in 76% after LEB and 41% after EV ($p = 0.013$). This difference was significant in larger wounds (Group C) with complete healing in 70% LEB and 27% EV ($p = 0.02$). A shorter median time to healing was noted after bypass; LEB 98 days, EV 132 days ($p = 0.048$). There were 40 amputations; EV 30 (20% total, 8% major), and LEB 10 (7% total, 2.8% major).

Conclusions: This comparison of wound healing after bypass or endovascular revascularization demonstrates more complete healing and a faster rate of healing after open bypass for larger wounds (> 2 cm). Initial wound size should be a consideration in choosing the method of revascularization for ischemic wounds.

Healing based on initial wound size

Group	*LEB*	*EV*
A (0-5 mm)	81.1% 94 days	53.8% 105 days
B (5.1 – 20 mm)	76.2% 102 days	41.7% 128 days
C (> 20 mm) *	70.2% 115 days	27.1% 164 days

*$p = 0.01$

Author Disclosures: C. E. Attinger: Nothing to disclose; **J. Babrowicz**: Nothing to disclose; **D. Deaton**: Nothing to disclose; **J. Laredo**: Nothing to disclose; **R. F. Neville**: WL Gore, Honorarium; **J. Steinberg**: Nothing to disclose.

VS 3.

Video Presentation
Popliteal to Dorsalis Pedis Translocated Vein Graft

Frank W. LoGerfo[1], Frank B. Pomposelli[1], Allen Hamdan[1], Bernadette Aulivola[2]. [1]Beth Israel Deaconess Medical Center, Boston, MA; [2]Loyola University Medical center, Chicago, IL

Background: Autogenous vein bypass grafts to the dorsalis pedis artery are an essential surgical skill in the care of patients with foot ulcers associated with Diabetes Mellitus.

Technical Description: This is a video showing the key steps in the performance of a popliteal to dorsalis pedis translocated vein graft demonstrating angioscopically verified valve lysis.

Author Disclosures: B. Aulivola: Nothing to disclose; **A. Hamdan**: Nothing to disclose; **F. W. LoGerfo**: Nothing to disclose; **F. B. Pomposelli**: Nothing to disclose.

SS17.

Vacuum-Assisted Closure (VAC) Therapy for the Treatment of Deep (Szilagyi Grade III-Infection) in the Groin

Ramesh Tripathi[1], Kiriakos Ktenidis[2]. [1]Vascular & Endovascular Surgery, Indraprastha Apollo Hospital, New Delhi, Hungary; [2]Aristotle University, Thessaloniki, Greece

Objectives: To evaluate the benefit of vacuum-assisted closure (VAC) therapy for the treatment of deep alloplastic graft infections (Szilagyi Grade III-Infection) in the groin.

Methods: From 2000 to 2009, 72 deep inguinal infections involving native as well as synthetic graft or patch material. There were 29 early graft infections (< 30 days after implantation) and 43 late infections. 55 cases involved non-native grafts/patches (26 PTFE grafts, 24 Dacron grafts, 5 Vascuguard Bovine Pericardial patches). All patients were treated with multiple wound debridements, graft salvage, sartorius myoplasty, IV antibiotics and VAC dressings till thru-surface healing was achieved. Exclusion criteria were an alloplastic graft infection with proximal expansion above the inguinal ligament, blood culture positive septicaemia or septic anastomotic herald or overt bleeding.

Results: At 9 months, overall, graft/patch salvage was achieved in 70/72 (97.2%) patients. In the non-native group, vein or synthetic graft preservation without revision was achieved in 48/55 (82.27%) patients. The mean duration of VAC treatment was 16 ± 7.7 days, postoperative mean hospital stay was 25.3 ± 8.5 days. In 23 (31.9%) cases a secondary closure of the wound could be achieved. In 49 cases wound healing was achieved by meshed split skin grafting. Mean wound healing time for all wounds was 24.3 ± 12.5 days. Mean postoperative follow-up was 4.3 ± 3.5 years with no procedure-related mortality. Specific complications during VAC-therapy were wound fluid retention in 2 cases and an increased need for analgesics in 12 patients.

Conclusions: Even in the presence of synthetic vascular graft material, negative pressure therapy can greatly simplify challenging wound-healing problems. Our long-term experience demonstrates the safety and effectiveness of VAC-therapy for the treatment of deep graft infections.

Author Disclosures: K. Ktenidis: Nothing to disclose; **R. Tripathi**: Nothing to disclose.

SS18.

Low Rehospitalization Rate for Vascular Surgery Patients at a Single University Hospital

Benjamin M. Jackson[1], Lynne Doctor[2], Derek Nathan[3], Grace J. Wang[1], Edward Y. Woo[1], Ronald M. Fairman[1]. [1]Hospital of the Univeristy of Pennsylvania - Division of Vascular Surgery, Philadelphia, PA; [2]University of Pennsylvania School of Medicine, Philadelphia, PA; [3]General Surgery, Hospital of the University of Pennsylvania, Philadelphia, PA

Objectives: Reducing rehospitalization rates has been proposed to improve care, reduce costs, and as a pay-for-performance criterion. Recent review of Medicare claims